

# Dental SelectHMO plan for individuals and families



## Dental benefits you can smile about!

### Dental care is important to your health

Besides helping you keep a great smile, regular dental check-ups can help find early warning signs of health issues. That's one reason why it's so important to take good care of your teeth and gums. And the Dental SelectHMO plan from Anthem Blue Cross can help make it easy and affordable.

### How the Dental SelectHMO plan works

Our Dental SelectHMO plan offers full coverage designed to fit your budget. To be covered, you have to get services from a dentist in the Anthem Blue Cross Dental SelectHMO dental network. You can choose from more than 6,600 locations in California.

**It's easy to find a network dentist. Visit [anthem.com/ca](http://anthem.com/ca). Choose the "Find a doctor" tool.**

Once you become a member, you can start using your benefits (for most services) right away. And you won't have to meet any deductibles. (A deductible is the amount of money you have to pay out of pocket before Anthem Blue Cross pays for any services.)

Each time you visit an in-network dentist, you pay a low \$5 office visit copay. (A copay is the amount you pay for a visit, service or procedure.) Depending on what service you have, you may also have a separate copay for that service. Services such as cleanings, exams and X-rays are covered in full with no other copays. Charts on the next page show examples of dental services and copays under the plan.

### What Dental SelectHMO costs

Take advantage of the plan's many features, including no deductibles and no yearly maximums. The best part: people of any age may apply!

Monthly rates (effective 5/1/11) for Dental SelectHMO plan enrollees under age 65 <sup>1</sup>	Monthly rates (effective 3/1/10) for Dental SelectHMO plan enrollees age 65 and older <sup>1</sup>
Single <b>\$1740</b>	Single <b>\$13.00</b>
Two people (member and spouse or member and child) <b>\$35.50</b>	Two people (member and spouse or member and child) <b>\$26.00</b>
Family (three or more) (member, spouse and child or member and children) <b>\$53.30</b>	Family (three or more) (member, spouse and child or member and children) <b>\$39.00</b>

### Dental SelectHMO counties

Dental SelectHMO is available if you live in the counties of Alameda, Contra Costa, Fresno, Los Angeles, Orange, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Mateo, Santa Clara and Ventura.

There is limited availability in the counties of Butte, El Dorado, Imperial, Kern, Madera, Marin, Monterey, San Joaquin, San Luis Obispo, Santa Barbara, Santa Cruz, Solano, Sonoma, Stanislaus, Tulare, Tuolumne and Yolo.<sup>1</sup>

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## Dental SelectHMO benefits at a glance

### Basic dental care covered benefits

These copays are only for services from an in-network dentist. *Specialty* services by an in-network *specialty* dentist are on a separate schedule of costs. Check the contract schedule for details.

Dental services	Copays
Office visit . . . . .	\$5
<b>Diagnostic care (X-ray)</b>	
Oral exams . . . . .	No charge
X-rays . . . . .	No charge
<b>Preventive care</b>	
Routine cleanings (adult and child) . . . . .	No charge <sup>2</sup>
Topical fluoride (child) . . . . .	No charge
<b>Restorative care</b>	
Permanent filling – 1 surface amalgam . . . . .	No charge <sup>3</sup>
Permanent filling – 2 surfaces amalgam . . . . .	No charge <sup>3</sup>
Permanent filling – 3 surfaces amalgam . . . . .	No charge <sup>3</sup>
Permanent filling – 4 or more surfaces amalgam . . . . .	No charge <sup>3</sup>
Permanent filling – 1 surface posterior resin composite . . . . .	\$75

### Ready to get covered?

To apply, follow the directions on the Individual Dental SelectHMO Plan Enrollment Application. Note: You must choose a general dentist who is in-network and write the dentist's name on your application. You and your dependents must select the same in-network general dentist.

Send your application (and payment, if required) to your independent agent or to Anthem Blue Cross.

#### To submit to Anthem Blue Cross

You may fax to (866) 931-1829 if you are:

- paying by electronic check,
- paying first month's premium by credit card, or
- signing up for monthly checking deduction.

If paying by paper check, please mail to the address below that applies to you:

#### Dental SelectHMO Plan enrollees under 65:

Anthem Blue Cross  
P.O. Box 9051  
Oxnard, CA 93031-9051

#### Dental SelectHMO Plan enrollees over 65:<sup>4</sup>

Anthem Blue Cross  
P.O. Box 9063  
Oxnard, CA 93031-9063

### Even more plan benefits

Dental services	Copays
<b>Endodontic care (root canals)</b>	
Root canal	
anterior . . . . .	\$289
bicuspid . . . . .	\$341
molar . . . . .	\$459
Pulpotomy . . . . .	\$62
<b>Periodontal care (gums)</b>	
Scaling/root planning per quadrant . . . . .	\$101 <sup>3</sup>
Gingivectomy	
per tooth . . . . .	\$72
per quadrant . . . . .	\$194
Osseous surgery per quadrant . . . . .	\$520
<b>Oral surgery</b>	
Extraction (single tooth) . . . . .	\$60 <sup>3</sup>
Impaction	
soft tissue . . . . .	\$136
partial bony . . . . .	\$176
complete bony . . . . .	\$200
<b>Prosthodontic care (crowns, bridges, dentures)</b>	
Crown - porcelain fused high noble metal . . . . .	\$432
Complete upper or lower dentures . . . . .	\$577
Partial denture . . . . .	\$430
Denture (broken tooth repair) . . . . .	\$57
<b>Orthodontic care (braces)</b>	
Orthodontics (child) . . . . .	\$2,870
Orthodontics (adult) . . . . .	\$3,045
Retention . . . . .	\$210
<b>Cosmetic care</b>	
Resin filling (permanent, one surface, posterior) . . . . .	\$75
Labial veneer (laminare) – chairside . . . . .	\$187
<b>Other services</b>	
Office visit after hours . . . . .	\$56
Local anesthesia . . . . .	\$14

**This gives only a brief description of some plan features. This is not the insurance contract. Only the Certificate of Coverage (“Certificate”) rules apply. Please see your Certificate for more details, benefits, limitations and exclusions. If there are any conflicts between the information in the Certificate and the information listed here, the information in the Certificate applies.**

**For a full description of all dental benefits, limitations and exclusions, please contact your Anthem Blue Cross sales rep.**

1 Subject to change.

2 First two treatments in 12 consecutive months. All extra treatments within a 12-month period require copays of \$44 for adults and \$35 for children.

3 You must meet a six-month waiting period before these benefits are payable.

4 Eligibility, rates and billing options for the Dental SelectHMO plan vary for individuals over 65. Please contact your agent or call 800-765-2585 for more information.



**Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company  
Individual Dental Plan Enrollment Application  
for individuals and families under age 65**

Send your completed application and payment to:  
Anthem Blue Cross  
P.O. Box 9051  
Oxnard, CA 93031-9051

If you are an Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company member, please enter your current group number and certificate number.

GROUP NO.	CERTIFICATE NO.

**Plan choice - select one**  
Dental Blue PPO plans provided by Anthem Blue Cross Life and Health Insurance Company

**Dental HMO Plans provided by Anthem Blue Cross**

- Dental Blue Basic                       Dental SelectHMO  
 Dental Blue Enhanced                 Other \_\_\_\_\_

If you choose the Dental SelectHMO plan, you must enter the number of the Dental Office you have chosen: \_\_\_\_\_

**Application Information: Applicant must complete this section.**

**PLEASE PRINT**

LAST NAME	FIRST NAME	MI	SEX <input type="checkbox"/> M <input type="checkbox"/> F	BIRTHDATE (Mo/Day/Year)	MARITAL STATUS <input type="checkbox"/> S <input type="checkbox"/> M	SOCIAL SECURITY NUMBER
HOME ADDRESS (Must be complete, P.O. Box not acceptable)			BILLING ADDRESS, IF DIFFERENT (or P.O. Box)			
CITY	STATE	ZIP CODE	CITY	STATE	ZIP CODE	
HOME PHONE NO. (    )			BUSINESS PHONE NO. (    )			

**Spouse/Domestic Partner To Be Insured (Sign Below)**

NAME OF SPOUSE/DOMESTIC PARTNER	SEX <input type="checkbox"/> M <input type="checkbox"/> F	BIRTHDATE (Mo/Day/Year)	SOCIAL SECURITY NUMBER
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**Children To Be Insured**

NAME (First and Last) 1.	SEX <input type="checkbox"/> M <input type="checkbox"/> F	BIRTHDATE (Mo/Day/Year)	NAME (First and Last) 3.	SEX <input type="checkbox"/> M <input type="checkbox"/> F	BIRTHDATE (Mo/Day/Year)
NAME (First and Last) 2.	SEX <input type="checkbox"/> M <input type="checkbox"/> F		NAME (First and Last) 4.	SEX <input type="checkbox"/> M <input type="checkbox"/> F	

**Language Preference** - When information is sent to you, we may be able to send it in a language other than English. What language would you prefer? (Optional)

Spanish  Chinese  Korean  Japanese  Tagalog  Vietnamese  Khmer  Hmong  Farsi  Arabic  Armenian  Russian  Other \_\_\_\_\_

**Signatures (Required)**

**Statement of Understanding for Dental Blue PPO plan applicants in areas with limited availability:** I understand the difference between a Participating Dentist and a Non-Participating Dentist, and would like to apply. I know that I probably will not be able to use a Participating Dentist and that I will probably pay more for dental care. When I use Non-Participating Dentists, I will pay the difference between the limited benefit that the plan pays and the actual charge by the Non-Participating Dentist. This means that I may be responsible for a larger portion of my dental bills.

**Statement of Understanding for Dental SelectHMO plan applicants:** I understand that, once enrolled, only the services I receive from my Anthem Blue Cross Dental SelectHMO participating provider will be covered by the plan.

**REQUIREMENT FOR BINDING ARBITRATION**

The following provision does not apply to class actions:

**IF YOU ARE APPLYING FOR COVERAGE, PLEASE NOTE THAT ANTHEM BLUE CROSS AND ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY REQUIRE BINDING ARBITRATION TO SETTLE ALL DISPUTES INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY AND CLAIMS OF MEDICAL MALPRACTICE, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT. It is understood that any dispute including disputes relating to the delivery of services under the plan/policy or any other issues related to the plan/policy, including any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. THIS MEANS THAT YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY ARE WAIVING THE RIGHT TO A JURY TRIAL FOR BOTH MEDICAL MALPRACTICE CLAIMS, AND ANY OTHER DISPUTES INCLUDING DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY.**

SIGNATURE OF APPLICANT/PARENT OR LEGAL GUARDIAN <b>X</b>	TODAY'S DATE	SIGNATURE OF APPLICANT'S SPOUSE/DOMESTIC PARTNER <b>X</b>	TODAY'S DATE
SIGNATURE OF APPLICANT'S DEPENDENT AGE 18 OR OVER <b>X</b>	TODAY'S DATE	SIGNATURE OF APPLICANT'S DEPENDENT AGE 18 OR OVER <b>X</b>	TODAY'S DATE

**Agent Information and Declaration**

To the best of my knowledge, the information on this application is complete and accurate. I have explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information and the applicant understands the explanation. I understand that if I willfully make any false representations I shall, in addition to any applicable penalties or remedies available under current law, be subject to a civil penalty of up to \$10,000.

SIGNATURE OF AGENT <b>X</b>	AGENT NAME (PRINT)	AGENT NUMBER
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**FOR ANTHEM BLUE CROSS ONLY**

GROUP NO.	CERTIFICATE NUMBER	AGENT NO.	EFFECTIVE DATE	PRE-EXIST	AREA	BY	DATE
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